Louisiana Morbidity Report

Louisiana Office of Public Health - Infectious Disease Epidemiology Section
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January-February **Volume 11 Number 1**

Influenza Vaccination Trends

Data on self-reported influenza vaccination status in Louisiana among non-institutionalized seniors, 65 years and older, is available for five years (1993, 1995-1998) from the Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is an ongoing statewide telephone surveillance system that collects data on self-reported behaviors and conditions. An average of 299 seniors (65 years and older) was interviewed each year.

In 1998, 59.7% of the Louisiana senior adult population reported receiving a flu vaccination within the last 12 months. Senior males (58.8%) and females (60.3%) had similar rates. However, non-Hispanic whites were more likely than non-Hispanic blacks to be vaccinated, 62.9% and 52.0%, respectively.

Vaccination trends are improving for all seniors. Although overall vaccination rates for Louisiana continue to be below those of the U.S. as a whole (Figure 1), Louisiana is approaching the Healthy People 2000 (HP2) objective of 60% coverage rates for adults aged 65 years and older. Positive vaccination trends occur for both males and females (Figure 2) with females surpassing the HP2 goals and males closely approaching. The white, non-Hispanic population showed a sharp increase from 1993 to 1995 with a stable level through 1998. However, non-Hispanic African Americans showed a negative trend from 1993-1996 (Figure 3) with a sharp increase in 1997.

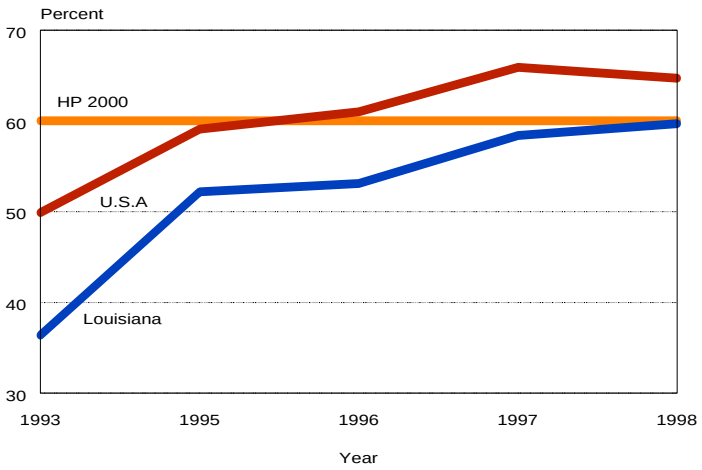
Influenza is responsible for significant morbidity and mortality during epidemics and causes thousands of deaths each year, mostly among the elderly. (The Louisiana Morbidity Report, September-October 1999 issue, reported an outbreak of influenza A in an adult day care center in Baton Rouge.) Influenza is spread by person to person contact and by airborne droplet spray. Due to changes in the influenza virus, the vaccine administered is updated each year. People at risk for developing a serious case or complications should be vaccinated. These include all people age 65 years and older, people with certain chronic medical disorders, and health care providers for high-risk patients.

Higher rates of vaccinations will result in lower influenza morbidity and mortality. It is vital to achieve total vaccination coverage for the elderly and immunocompromised. This includes a special focus to address the racial disparity in coverage rates. Additionally, health systems need experience in full and rapid response to the anticipated global influenza pandemic.

In the last three years, the OPH Immunization Program, the Alliance for Immunization Management, which is a coalition of

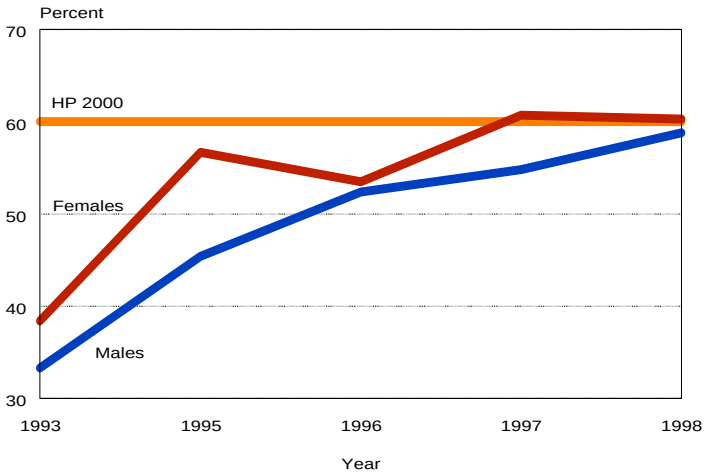
(Continue on next page)

Figure 1: Influenza vaccination rates, Louisiana vs USA, 1993 and 1995-1998*



* BRFSS, Chronic Disease Control Section

Figure 2: Influenza vaccination rates by sex, Louisiana, 1993 and 1995-1998*



* BRFSS, Chronic Disease Control Section

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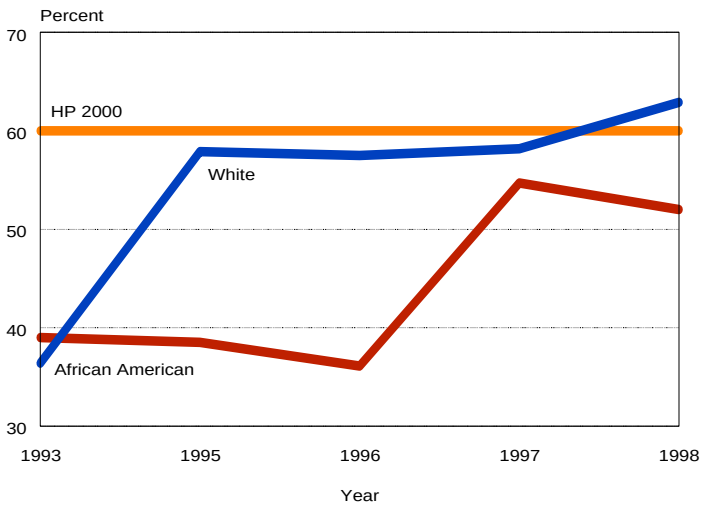
Figure 3: Influenza vaccination rates by race, Louisiana, 1993 and 1995-1998*



* BRFSS, Chronic Disease Control Section

physicians, non-profit organizations, senior advocates, and others, are working towards increasing flu protection in Louisiana. Since the inception of this collaboration, there have been significant increases in statewide coverage as reflected in this data. The coalition continues to conduct outreach programs and educate the public about the availability and importance of influenza vaccination.

Spinal Cord Injury Among Louisiana's Youth

In 1997, 330 Louisiana residents sustained a spinal cord injury (SCI). This resulted in an overall SCI incidence rate of 7.6 per 100,000 in Louisiana, almost twice as high as the national rate of 4 per 100,000. Males were 3.7 times more likely to experience a spinal cord injury than females, with incidence rates of 12.4 per 100,000 and 3.1 per 100,000 respectively. Males between the ages of 25 and 34 had the highest SCI rates, followed closely by the 35 to 44 age group and the 15 to 24 age group (Figure 1). Black males were two times more likely to experience a SCI (18 per 100,000) than white males (9 per 100,000). White females (2.8 per 100,000) and black females (3.1 per 100,000) had similar SCI incidence rates. Motor vehicle crashes (46%) were the leading cause of spinal cord injury among Louisiana residents, followed by falls (24%), violence-related injuries (22%), other injuries (6%), and sports-related injuries (2%).

Nearly 18 percent (N=58) of SCIs in Louisiana occurred among persons 21 years of age and younger (an incidence rate of 4 per 100,000). Young males were 4.6 times more likely to sustain a SCI than their female counterparts, with incidence rates of 6.4 per 100,000 and 1.4 per 100,000 respectively. Black males had the highest incidence rate (9.6 per 100,000), followed by white males (3.6 per 100,000), white females (2.1 per 100,000), and finally black females (0.3 per 100,000). Among this age group, 50 percent of all injuries resulted in complete or incomplete, non-functioning spinal cord injuries, while the remaining 50 percent regained some level of functioning. Overall, the leading cause of SCI among Louisiana residents under the age of 22 was motor-vehicle crashes (44%), followed by violence-related injuries (29%), falls (15%), other injuries (7%), and sports-related injuries (5%).

When the external cause of SCI is examined more closely and stratified by race and sex, many interesting differences should be noted. Overall, very few young, black females are sustaining SCI in Louisiana. On the other hand, many young, black males are the victims of SCI. Young white males and females are experiencing SCI at comparable rates. The causes of spinal cord injuries among young blacks and whites differ dramatically. Figure 2 shows the external cause of SCI breakdown for young black Louisiana residents and Figure 3 shows this breakdown for young white Louisiana residents. Among young Louisiana residents who sustain a SCI, young blacks are 3.8 times (Relative Risk = 3.8, 95% Confi-

Figure 1: Incidence rates of SCI among Louisiana residents by age group, 1997 (N=330)

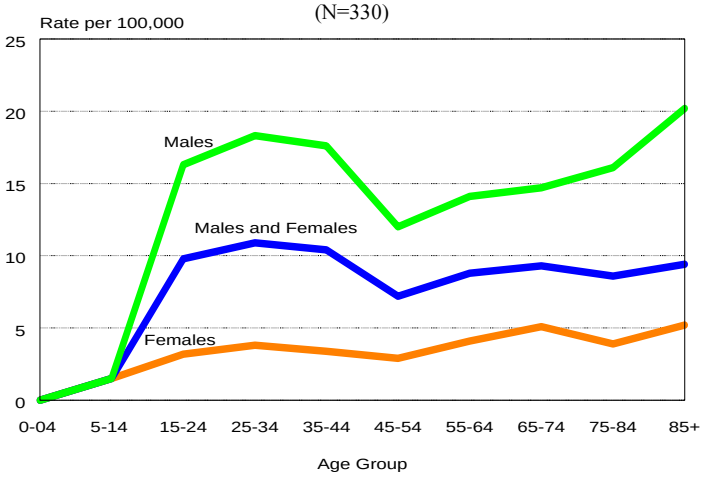


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Figure 2: External cause of SCI among young, black Louisiana residents, 1996-1997

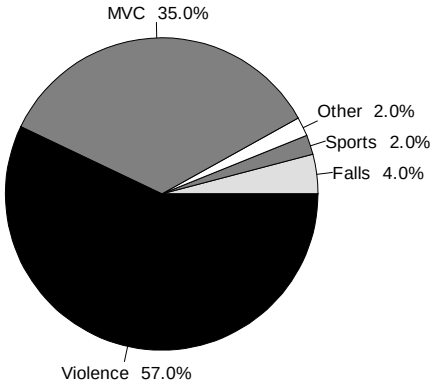
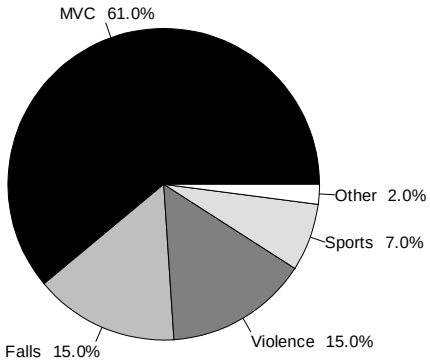


Figure 3: External cause of SCI among young, white Louisiana residents, 1996-1997



dence Interval: 1.82 – 7.75) more likely to have been a victim of a violence-related injury than their white counterparts. On the other hand, young whites are 1.8 times (Relative Risk = 1.8, 95% Confidence Interval: 1.12 – 2.75) more likely to have sustained a SCI due to a motor- vehicle crash than young blacks.

Modified Guidelines for Meningococcal Vaccine

On October 20, 1999, the Advisory Committee on Immunization Practices (ACIP) has modified its guidelines for use of the polysaccharide meningococcal vaccine to prevent bacterial meningitis, particularly for college freshman who live in dormitories, a group found to be at a modestly increased risk of meningococcal disease. ACIP now recommends that those who provide medical care to this group give information to students and their parents about meningococcal disease and the benefits of vaccination. Vaccination should be provided or made easily available to those freshman (or other undergraduates) who wish to reduce their risk of disease. A single dose of the vaccine is recommended, and vaccination will decrease the risk of disease caused by *N. meningitidis* serogroups A, C, Y, and W-135, but does not protect against serogroup B. Although it is highly effective against serogroups C and Y, it still does not confer 100% protection against these serogroups. In 1998-1999, serogroups C and Y caused about 70% of cases among college students.

Revised Immunization Schedule

The Office of Public Health has released the new Immunization Schedule. This publication is one method by which changes in immunization policy affecting institutions of higher learning, schools, pre-schools, childcare facilities, and the Head Start Programs are announced. This schedule, dated December 8, 1999, supersedes all previous editions.

The schedule is based upon specific vaccine recommendations made by the American Academy of Pediatrics (AAP) and the Advisory Committee on Immunization Practices (ACIP) to the United States Public Health Service (USPHS). There are three (3) major areas wherein the Office of Public Health Immunization Schedule has been changed. In summary, these include:

- The elimination of routine administration of OPV, to an all IPV schedule
- The use of Thimerosal-free HBV at birth, and
- The requirement of varicella vaccine for enrollment in schools, pre-schools, Head Start, and childcare facilities beginning in the fall of 2003.

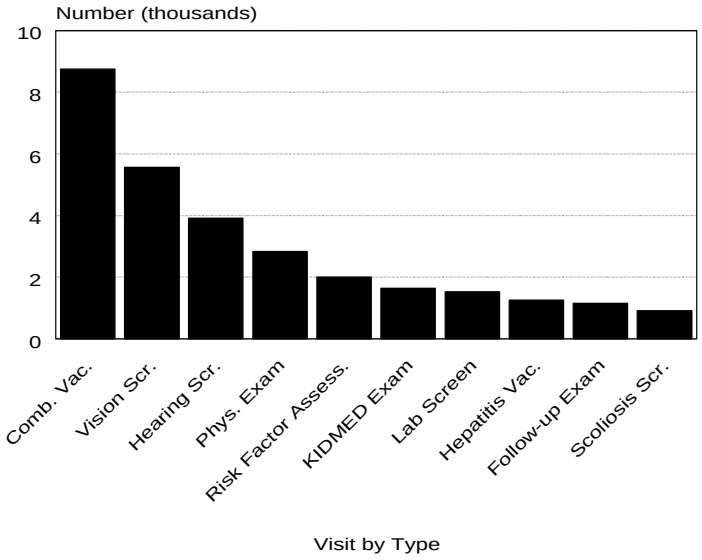
Should you have any questions or would like to obtain a copy of the official Louisiana Immunization Schedule, please contact the Immunization Program at (504) 483-1900.

Louisiana School-Based Health Centers

At the end of 1999, there were 37 school-based health centers (SBHCs) in operation throughout Louisiana. In the year ending June 30, 1999, over 100,000 visits were made by nearly 21,000 children of which 55% of the visits were female and 45% male. The racial breakdown was 64%, 35%, and 1% for African American, Caucasian, and other, respectively. Although center locations are evenly divided between urban and rural sites, 61% of those seen were from rural areas. SBHCs serve students ranging from headstart through 12th grade; however, 7th and 8th grade children made the most visits (37%) last year. There was an average of 4.8 visits per student.

The reasons for a visit ranged from physical examinations and risk behavior assessments to mental health counseling and asthma control. General preventive medicine was the most common reason for a visit followed by mental and behavioral health. The reasons associated with a general preventive medicine visit ranged from vaccination to vision and hearing screening to risk factor assessment (Figure 1). A vast majority of the mental and behavioral health visits were due to relational problems. Headache and abdominal pain were the most common conditions for injury or illness related visits (Figure 2). Health education visits focused on the prevention and control of disease and disorders, family life, and personal and nutritional health.

Figure 1: Leading reasons for general preventive medicine visits*

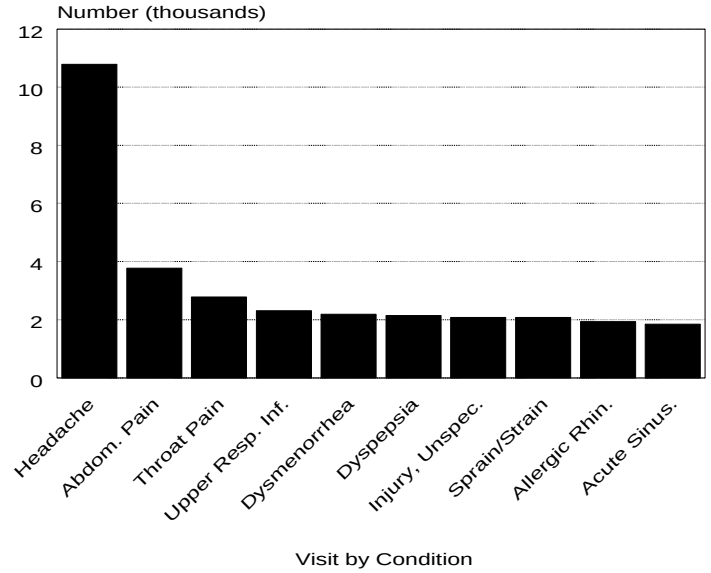


* Louisiana School-Based Health Centers, 1998-1999 school year

In addition to the above-mentioned services, SBHC also administered medication and managed chronic diseases such as asthma and diabetes. SBHCs address a number of children's unmet health needs by:

- Providing healthcare where children are located
- Supporting families by helping to keep children healthy and limiting occasions when parents must skip work
- Reducing absenteeism and identifying students at risk for violence and substance abuse.

Figure 2: Leading conditions for injury and illness related visits*



* Louisiana School-Based Health Centers, 1998-1999 school year

Global Poliomyelitis Eradication

Ten years after the year 2000 target was set by the World Health Assembly, the global poliomyelitis eradication effort has made significant progress towards that goal. The single most important factor in the continuing success of poliomyelitis eradication is political commitment within the endemic countries. Eradication activities are conducted by the countries with the assistance of the international community.

Routine coverage with three doses of oral poliovirus vaccine (OPV) worldwide has remained above 80% since 1990. Coverage is lowest in the African Region, where 12 countries are unable to immunize even 50% of infants born. As of March 1998, at least one round of national immunization days (NIDs) had been conducted in all polio-endemic countries with the exception of the Democratic Republic of the Congo, Liberia, Sierra Leone, and Somalia. In 1997, more than 450 million children were immunized during NIDs in 80 countries worldwide. Acute flaccid paralysis (AFP) surveillance has been implemented in 142 countries. The rate of AFP cases reported is substantially below the target of 1 per 100,000 annually in the African Region, where AFP surveillance is in the early phases of implementation.

The number of poliomyelitis cases reported to WHO declined by 88% between 1988 (35,252 cases) and 1996 (4,074 cases). As of April 1998, 3376 cases were reported for 1997. However, reporting is incomplete and the final total for 1997 will approach 4000 cases. Poliomyelitis eradication was certified in the Americas in 1994, the last case being reported from Peru in September 1991. One year has elapsed since the last case of poliomyelitis was reported from the WHO Western Pacific Region. In the European Region, six virologically confirmed cases were reported in 1997, all from south-eastern Turkey. West and central Africa remain heavily endemic, with the Democratic Republic of the Congo and Nigeria serving as major reservoirs of wild poliovirus. South Asia is the other major global reservoir with Afghanistan, Bangladesh, India, Nepal and Pakistan remaining heavily endemic. Wild poliovirus, type 2, was identified in 1997 from only three countries - Afghanistan, India and Pakistan.

The progress achieved proves that existing technology and WHO-recommended strategies (high routine immunization coverage, mass campaigns, AFP surveillance) are sufficient to eradicate poliomyelitis worldwide. Significant challenges remain, however. Eradicating the disease in the remaining endemic countries will be particularly difficult because of their relative poverty, poor health infrastructure, difficult geography, dispersed populations, and ongoing armed conflict.

While the last case of poliomyelitis is still several years in the future, the success of the global poliomyelitis eradication initiative can serve as a model for future disease eradication and elimination initiatives.

(Source: MMWR, 1999, Vol.48/Supplement)

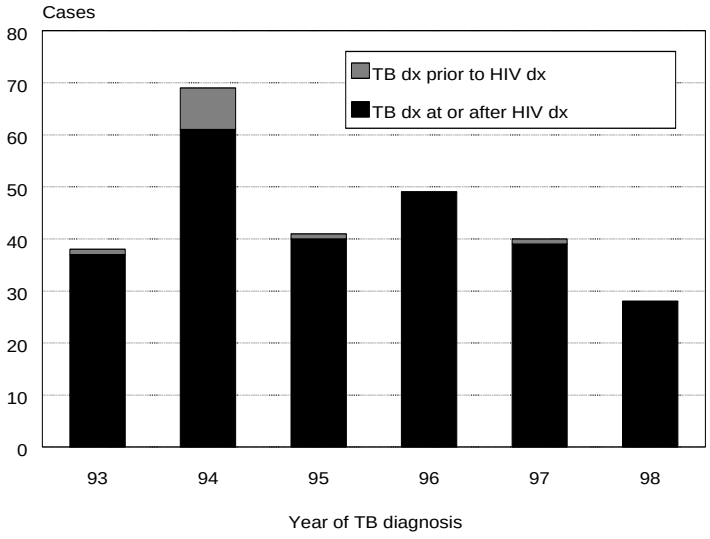
HIV/AIDS Update

HIV/AIDS and Tuberculosis

Immunocompromised persons are at greater risk for tuberculosis (TB) and antiretroviral treatment may decrease the risk of activating TB among persons infected with HIV infection. In order to determine the rate of and the risks for TB among HIV positive persons in Louisiana, 5.5 years of data from the statewide HIV/AIDS and TB reporting systems were analyzed. Sixteen thousand and thirty-six adult HIV/AIDS cases, alive by November 1993 and reported by the end of 1999, were matched against all cases of active TB reported between November 1993 and June 1999.

The match identified 270 cases of persons reported to both systems. Tuberculosis among HIV-infected persons peaked in 1994 and may be decreasing slightly since then (Fig 1). The tuberculosis rate was 1.8% among HIV/AIDS cases and the HIV prevalence was 11.3% among all reported TB cases. Ninety-five percent (95%) of the coinfected cases were diagnosed with TB either at or after the time HIV was diagnosed. Among those, 35% were diagnosed with both TB and HIV within the same year. The majority of the coinfected cases were diagnosed with pulmonary TB (81.9%), an AIDS-defining criterion, followed by lymphatic-cervical TB (4.4%) and pleural TB (3.7%).

Figure 1: HIV/TB coinfected cases by year of TB diagnosis, Louisiana, 1993-1998



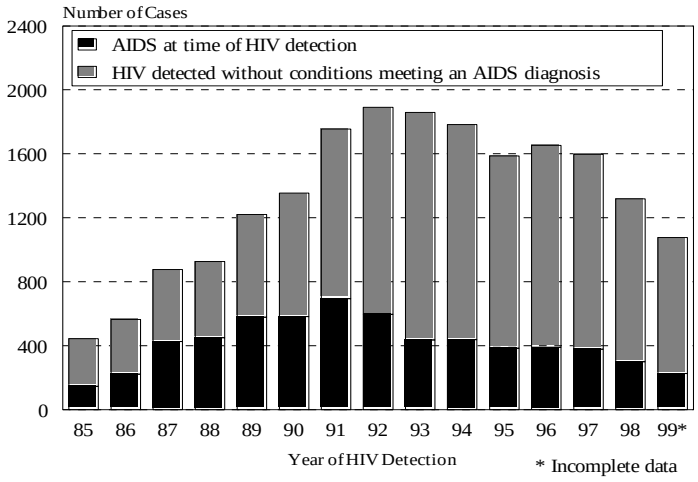
In order to describe TB and HIV coinfection, the basic demographics and risks among HIV-infected persons with TB were compared to those without TB using logistic regression. [Coinfected cases were more likely to be male, African-American, under 35, in Metro New Orleans, IV drug users or men who have sex with men (MSM), reported with HIV prior to 1996, and diagnosed in a public facility (Table 1)].

Table: Characteristics of TB and HIV Coinfection: results from logistic regression

		TB among HIV-infected		Odds	
		#	%	Ratio	Conf Limits
Race	Afr-Am	179	1.9	1.45	(1.10, 1.92)
	Non AA	91	1.6		
Gender	Male	234	2	1.58	(1.07, 2.33)
	Female	36	1		
Age group	<35	152	2.5	1.67	(1.30, 2.14)
	>35	118	1.3		
Mortality	Dead	114	3.9	2.96	(2.29, 3.82)
	Alive	129	1.1		
Year of HIV	Dx<96	212	2.1	1.42	(1.03, 1.94)
diagnosis	Dx≥96	58	1.1		
IV Drug Use	IDU	72	2.6	1.82	(1.28, 2.59)
	Non-IDU	198	1.6		
Men who have	MSM	132	2.2	1.5	(1.06, 2.120)
sex with men	Non-MSM	138	1.5		
High Risk	HRH	24	1.3	Ns	
Heterosexual	Non-HRH	246	1.9		
Metro New	Metro NO	169	2.2	1.64	(1.28, 2.12)
Orleans	Rest LA	101	1.4		
Facility ofHIV	Public	164	1.9	1.42	(1.10, 1.84)
Diagnosis	Not public	106	1.7		

Proper TB prevention remains an important health issue because HIV prevalence is increasing and because the risk of drug-resistant TB is especially problematic in persons with HIV. Preventive measures against TB are skin testing for tuberculin with follow-up, contact investigations, and therapy management. For further information on the prevention and treatment of TB among HIV infected persons, see the guidelines published in MMWR 1998, 47 (RR-20).

HIV/AIDS TRENDS



LOUISIANA COMMUNICABLE DISEASE SURVEILLANCE
November - December, 1999
PROVISIONAL DATA
Table 1. Disease Incidence by Region and Time Period

DISEASE	HEALTH REGION 1	2	3	4	5	6	7	8	9	TIME PERIOD Nov-Dec 1999	Nov-Dec 1998	Jan - Dec Cum 1999	Jan - Dec Cum 1998	% Chg
Vaccine-preventable														
H. influenzae (type B)	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Hepatitis B Cases	0	3	1	1	0	2	1	1	2	11	29	167	192	-14.1
Rate[1]	0	0.5	0.3	0.2	0	0.7	0.2	0.3	0.5	0.25	0.7	3.9	4.4	
Measles	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Mumps	1	0	0	0	0	0	0	0	0	1	0	11	8	+37.5
Rubella	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Pertussis	0	0	0	0	0	0	0	0	0	0	0	10	11	-9.1
Sexually-transmitted														
HIV/AIDS Cases[2]	55	24	1	7	8	1	5	3	2	106	220	1396	1632	-14.5
Rate[1]	5.3	4.4	0.3	1.4	3.1	0.3	1.0	0.9	0.6	2.5	5.2	33.1	38.7	
Gonorrhea Cases	566	262	118	166	109	83	413	225	131	2073	2070	13209	12489	+5.8
Rate[1]	54.5	46.1	31.3	32.2	40.7	27.2	81.6	64.1	34	49.1	49.1	313	295.9	
Syphilis (P&S) Cases	14	4	1	11	7	0	3	0	6	46	61	306	430	-28.8
Rate[1]	1.3	0.7	0.3	2.1	2.6	0	0.6	0	1.6	1.1	1.4	7.3	10.2	
Enteric														
Campylobacter	1	1	0	0	0	0	0	0	1	3	17	117	126	-7.1
Hepatitis A Cases	2	0	0	9	0	0	2	0	3	16	47	204	160	+27.5
Rate[1]	0.2	0	0	1.7	0	0	0.4	0	0.8	0.4	1.1	4.7	3.7	
Salmonella Cases	9	3	1	8	1	1	7	1	12	43	85	536	687	-22.0
Rate[1]	0.9	0.5	0.3	1.6	0.4	0.3	1.4	0.3	3.1	1	2	12.4	16	
Shigella Cases	14	3	0	1	0	0	3	0	0	21	38	165	327	-49.5
Rate[1]	1.3	0.5	0	0.2	0	0	0.6	0	0	0.5	0.9	3.8	7.6	
Vibrio cholera	0	0	0	0	0	0	0	0	0	0	1	0	3	-
Vibrio, other	0	0	0	0	0	0	0	0	1	1	11	24	54	-55.6
Other														
H. influenzae (other)	0	0	0	0	0	0	1	0	0	1	4	13	28	-53.6
N. Meningitidis	1	0	0	0	0	0	2	0	0	3	11	58	70	-17.1
Tuberculosis	16	6	4	1	3	2	15	7	3	57	82	357	379	-5.8

1 = Cases Per 100,000

2 = These totals reflect cumulative totals of HIV+ and AIDS cases.

Table 2. Diseases of Low Frequency

Disease	Total to Date
Blastomycosis	3
E. coli o157:H7	12
Histoplasmosis	1
Lead Toxicity	15
Varicella	160
Rocky Mountain Spotted Fever	2
Legionellosis	4
Lyme Disease	11
Malaria	11
Tetanus	0

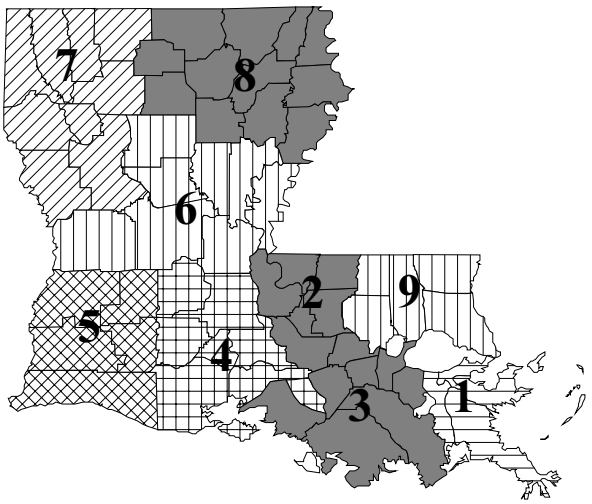


Table 3. Animal Rabies (November - December, 1999)

Parish	No. Cases	Species
Madison	1	Skunk

ANNUAL SUMMARY
Campylobacteriosis - 1998

One hundred forty-nine (149) cases of campylobacteriosis were diagnosed in 1998, resulting in a rate of 3.5 per 100,000. This was an 18% decrease from 1997. Rates of campylobacteriosis have remained fairly consistent since 1993 (Figure 1). Campylobacteriosis cases were reported in each month of the year, peaking during the summer months. Sex-specific rates were nearly identical in males and females (3.8 vs 3.2 per 100,000). However, race-specific rates were nearly three times higher for Whites when compared to Blacks (3.3 vs. 1.2 per 100,000 respectively). The largest number of cases were seen in males ages 0-4 years and 25-34 years and women over the age of 65 years of age (Figure 2). Livingston (13), Terrebonne (12), Caldwell (10) and St. Helena (10) parishes reported the highest rates per 100,000 of campylobacteriosis (Figure 3).

Figure 1: Cases of campylobacteriosis by year, 1989-1998

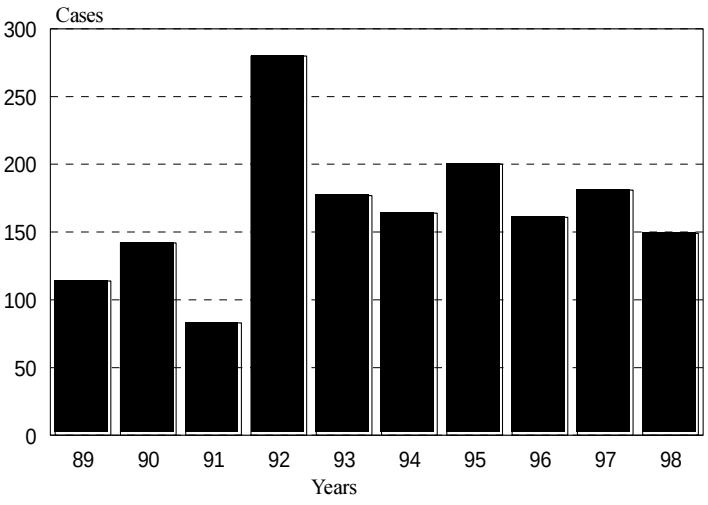
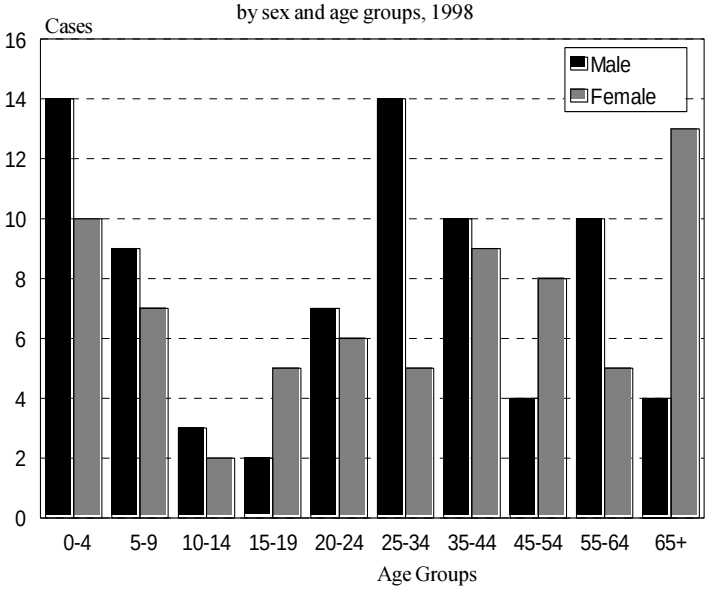


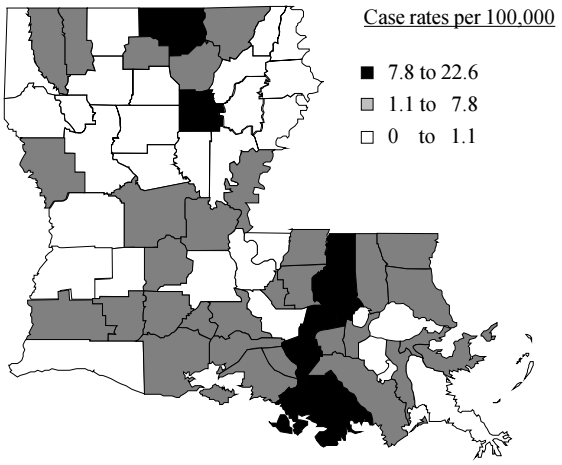
Figure 2: Cases of campylobacteriosis in Louisiana by sex and age groups, 1998



Comment:

Campylobacteriosis is one of the most common bacterial causes of diarrheal illness in the United States. It is a bacterial infection that affects the intestinal tract, and in rare instances, the bloodstream. Campylobacter is generally spread by eating or drinking contaminated food or water and, occasionally, by contact with infected people or animals. Most cases of campylobacteriosis are associated with handling raw poultry or eating raw or undercooked poultry meat. Campylobacteriosis can be prevented by safely handling raw food, avoidance of cross-contamination, thoroughly cooking all foods, and careful hand washing.

Figure 3: Rates of campylobacteriosis by parish, 1998



Louisiana Fact

The first etiological breakthrough for yellow fever is credited to Dr. Carlos Finlay of Havana who, in 1881, publicly suggested that yellow fever was transmitted from person to person by the ***Stegomyia fasciata*** *mosquito (since renamed* ***Aedes aegypti****). However, the specific organism causing the disease could not be identified, although investigators in many countries studied a multitude of "germs". In 1900, when a threatening outbreak of "yellow jack" occurred among American military personnel stationed near Havana, General Sternberg appointed Major Walter Reed to establish a medical board to pursue scientific investigations on yellow fever on the island of Cuba. In October 1900, Dr. Reed's Yellow Fever Commission was ready to present their findings to the American Public Health Association: "the mosquito [was] the intermediate host for the parasite of yellow fever." In a more complete report in February 1901 at the Pan-American Medical Congress held in Havana, among the striking conclusions was the assertion that the* ***Culex fasciatus*** *(the older name for* ***Stegomyia fasciata****) mosquito transmitted yellow fever by feeding on the blood of a person infected with the disease and later biting a nonimmune. The Commission concluded that "the spread of yellow fever can be most effectually controlled by measures directed to the destruction of mosquitoes and the protection of the sick against the bites of these insects."* ***Source: The Louisiana State Board of Health, The Progressive Years, by Gordon Gillson***

LIST OF REPORTABLE DISEASES/CONDITIONS

REPORTABLE DISEASES

Acquired Immune Deficiency Syndrome (AIDS)
Amebiasis
Arthropod-borne encephalitis (Specify type)
Blastomycosis
Botulism[1]
Campylobacteriosis
Chancroid[2]
Chlamydial infection[2]
Cholera[1]
Cryptosporidiosis
Diphtheria
Enterococcus (infection; resistant to vancomycin)
Escherichia coli 0157:H7 infection
Gonorrhea[2]
Haemophilus influenzae infection[1]
Hemolytic-Uremic Syndrome
Hepatitis, Acute (A, B, C, Other)
Hepatitis B carriage in pregnancy
Herpes (neonatal)
Human Immunodeficiency Virus (HIV) infection[3]
Legionellosis
Lyme Disease
Lymphogranuloma venereum[2]
Malaria
Measles (rubeola)[1]
Meningitis, other bacterial or fungal
Mumps
Mycobacteriosis, atypical[4]
Neisseria meningitidis infection[1]
Pertussis
Rabies (animal & man)
Rocky Mountain Spotted Fever (RMSF)
Rubella (German measles)
Rubella (congenital syndrome)
Salmonellosis
Shigellosis
Staphylococcus aureus (infection; resistant to methicillin/ oxacillin or vancomycin)
Streptococcus pneumoniae (infection; resistant to penicillin)
Syphilis[2]
Tetanus
Tuberculosis[4]
Typhoid fever
Varicella (chickenpox)
Vibrio infections (excluding cholera)[1]

OTHER REPORTABLE CONDITIONS

Cancer
Complications of abortion
Congenital hypothyroidism*
Severe traumatic head injury**
Galactosemia*
Hemophilia*
Lead Poisoning
Phenylketonuria*
Reye's Syndrome
Severe under nutrition (severe anemia, failure to thrive)
Sickle cell disease (newborns)*
Spinal cord injury**
Sudden infant death syndrome (SIDS)

Case reports not requiring special reporting instructions (see below) can be reported by Confidential Disease Case Report forms (2430), facsimile, phone reports, or electronic transmission.

[1] Report suspected cases immediately by telephone. In addition, all cases of rare or exotic communicable diseases and all outbreaks shall be reported.

[2] Report on STD-43 form. Report cases of syphilis with active lesions by telephone.

[3] Report on EPI-2430 card. Name and street address are optional but city and ZIP code must be recorded.

[4] Report on CDC 72.5 (f. 5.2431) card.

All reportable diseases and conditions other than the venereal diseases, tuberculosis and those conditions with *'s should be reported on an EPI-2430 card and forwarded to the local parish health unit or the Epidemiology Section, P.O. Box 60630, New Orleans, LA 70160, Phone: 504-568-5005 or 1-800-256-2748 or FAX: 504-568-5006.

* Report to the Louisiana Genetic Diseases Program Office by telephone (504) 568-5070 or FAX (504) 568-7722.

** Report on DDP-3 form; preliminary phone report from ER encouraged (504-568-2509). Information contained in reports required under this section shall remain confidential in accordance with the law.

Numbers for reporting communicable diseases

1-800-256-2748 Local # 568-5005 FAX # 504-568-5006

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